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ACCEPTANCE

This dissertation, INFLUENCE OF PSYCHOCULTURAL FACTORS AND SELF-STIGMA ON BIRACIAL INDIVIDUALS' COUNSELING UTILIZATION by, MARY ELIZABETH HUFFSTEAD, was prepared under the direction of the candidate's Dissertation Advisory Committee. It is accepted by the committee members in partial fulfillment of the requirements for the degree, Doctor of Philosophy, in the College of Education & Human Development, Georgia State University.

The Dissertation Advisory Committee and the student's Department Chairperson, as representatives of the faculty, certify that this dissertation has met all standards of excellence and scholarship as determined by the faculty.

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INFLUENCE OF PSYCHOCULTURAL FACTORS AND SELF-STIGMA ON BIRACIAL INDIVIDUALS' COUNSELING UTILIZATION

by

MARY ELIZABETH HUFFSTEAD

Under the Direction of Dr. Catherine Y. Chang

ABSTRACT

People of color (POC; African Americans, Asian Americans, Native Americans, and Latinx individuals) report to underuse mental health services in contrast to their White counterparts (Kim & Zane, 2016; Lou, Reddy & Hinshaw, 2010; SAMSHA, 2017; Yasui, Hipwell, Stepp, & Keenan, 2015). The barriers to counseling use reported for POC were poverty, insurance cost, mental illness, and stigma. Additionally, psycho-cultural barriers such as racial identity, discrimination, and self-stigma of mental health attributed to POC's underuse of psychological services (Cheng, Kwan, & Sevig, 2013). However, these findings are limited to monoracial POC, and no studies to date have investigated these factors in Biracial individuals. There is a paucity of research examining the barriers to mental health use for Multiracial individuals. The Multiracial population is one of the fastest growing racial groups in the United States, and this population is expected to double by 2060 (Pew Research, 2015). This study

addressed the gap in the literature by investigating the influences of racial identity integration, discrimination, and self-stigma on Biracial individuals' intentions to seek counseling. Chapter 1 provides an overview of the current literature organized in themes: mental health disparity (i.e., counseling utilization percentage for POC), racial identity (Biracial identity development models), discrimination (i.e., monoracism and microaggressions) and self-stigma (mental health stigmatization). Chapter 2 was a proposed study of the psychocultural factors (racial identity, discrimination, and self-stigma) impacts on mental health utilization of 202 individuals identifying with two racial groups (Biracial). At this time, one study has been found investigating Biracial individuals' attitudes toward counseling (Constantine & Gainor, 2004). Results of this study revealed that self-stigma of seeking (psychological) help did moderate the relationship between Biracial identity and intentions to seek counseling. The relationship between self-stigma of seeking (psychological) help did not moderate the relationship between intention to seek counseling. The findings signify the need to further understand the psychocultural barriers for Biracial individuals' attitudes and use of counseling. Limitation, counseling implications, and future research are discussed.

INDEX WORDS: Biracial, Multiracial, racial identity, discrimination, self-stigma of seeking help, mental health stigma, mental health disparity, counseling utilization

INFLUENCE OF PSYCHOCULTURAL FACTORS AND SELF-STIGMA ON BIRACIAL INDIVIDUALS' COUNSELING UTILIZATION

by

MARY HUFFSTEAD

A Dissertation

Presented in Partial Fulfillment of Requirements for the

Degree of

Doctor of Philosophy

in

Counselor Education & Practice

in

the Department of Counseling & Psychological Services

in

the College of Education and Human Development
Georgia State University

Atlanta, GA
2019

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DEDICATION

This dissertation is dedicated to my husband and best friend, Romero Huffstead, our son Liam, my sisters (Marva, Crystal, and Selena) my parents (Marvin and Rita Francis). Words cannot express the gratitude I have for your enduring support and encouragement during this journey to my Ph.D. To Romero, I cannot thank you enough for being my rock. Your reminders of my purpose during the stressful moments still echo in my ears today. Thanks for being my confidant and source of strength and stability throughout this journey. I love you! To Liam, because of you, I had the motivation to push through and finish strong. Mommy loves you! To my sisters, you all have been a constant source of love, support, and humor throughout this process. I am so grateful for your presence in my life. To my father, Marvin, your consistent push for excellence has taught me perseverance and unwavering dedication to "dig deep" and never give up. Thank you! To my mother, Rita, whose memory lives on in my heart and has kept me grounded and at peace during the late nights and early mornings during this journey, this one is for you my sweetest love.

ACKNOWLEDGMENTS

I want to express my appreciation for all the time and effort put forth by my dissertation committee members: Drs. Catherine Chang, Melissa Zeligman Franco Dispenza, and Asha Dickerson. Thank you for your many years of support that lead to this topic. Your feedback during this process was much appreciated. A special thank you to Dr. Catherine Chang for your invaluable mentorship and guidance as a counselor educator throughout the program. You have encouraged me to not only think like a "counselor first" but to strive to formalize what I am passionate about into action and research.

I want to acknowledge my colleagues, fellow students and friends, Dr. Melanie Varney, Dr. Kim Lee Hughes, Tianka Pharaoh, Nijel Ellison and Adeyinka Ogunbekun, your friendship and the love shown to me is something I will cherish for many years to come. Melanie, you are one of the reasons I finished; your words of encouragement continue to speak life into my purpose. Dr. Lee Hughes thank you for taking me under your wings and reminding me often of my greatness. Tianka, your support and encouragement played a critical role throughout my program and professional journey. Nijel and Adeyinka, you both have been my best friends since middle school, and I cannot think of anyone who has encouraged me throughout the years to be a better version of myself than you two. Thank you for showing me love and support for almost two decades and I know I have made you both proud. Thank you all for being one of my reasons and I love you all!

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1 MENTAL HEALTH DISPARITY, RACIAL IDENTITY, DISCRIMINATION, AND STIGMA OF MENTAL HEALTH

Multiracial individuals are one of the fastest growing populations in the U.S. According to the 2010 Census Briefs (Jones & Bullock, 2012), those who identify with two or more racial categories increased to almost 10 million from nearly 3 million ten years prior. The social categorizations of those from mixed racial heritage are commonly identified by specific terms, those being Biracial and Multiracial. Biracial identity implies having two racial or ethnic backgrounds. Multiracial identity has two or more racial or ethnic backgrounds. Within this study, the term Multiracial will be primarily used because the term is more inclusive of the various racial and ethnic make-ups. Throughout literature, the term Biracial and Multiracial has been used interchangeably to identify this population. The researcher will use the specific racial identification (Biracial or Multiracial) used within each study. With the growth of this population, there is an increasing need to understand and support Multiracial individuals. Over the past ten years, researchers have begun to uncover how racial identity formation and racial discrimination contribute to psychological distress of Multiracial individuals (Franco & O'Brien, 2018; Gaimo, Schmitt, & Outten, 2012; Jackson, Yoo, Guevarra, & Harrington, 2012; McDonald, Chang, Dispenza, & O'Hara, 2019). Biracial individuals experience the following psychological distress: anxiety, stress, and depression as a result of their racial identity (Jackson, Yoo, Guevarra, & Harrington, 2012). In response to the psychological distress this population experiences, scholars have shared counseling implications for working with Multiracial individuals (Constantine & Gainor, 2004; Henriksen & Paladino, 2009; Johnston & Nadal, 2010). Competencies for Counseling the Multiracial Population (Kenney, Kenney, Alvarado, Baden, Brew, …& Singh, 2015) was developed and endorsed by the American Counseling

Association (ACA) Governing Council to assist with training professional counselors how to support the Multiracial population better. Although there have been efforts made to prepare better professional counselors working with this group, there is a paucity of research addressing counseling utilization for Multiracial individuals. Therefore, data related to counseling utilization or mental health disparities of other people of color (POC) will be addressed. By unpacking the mental health disparity of all POC, it will help frame the mental health disparities that Multiracial individuals experience.

Moreover, literature about POC having to navigate psychocultural norms and experience with racial discrimination that produces psychological distress which impacts mental health-seeking behaviors (Carter & Forsyth, 2010; Richman, Kohn-Wood, & Williams, 2007) will assist in supporting the need to investigate similar experiences for Multiracial individuals. It is within reason to consider that Multiracial individuals who experience racial discrimination will have the same barriers seeking psychological services as POC which includes stigma (Barksdale & Molock, 2009; Cheng, Kwan, & Sevig, 2013; Masuda, Anderson, Edmonds, 2012; Ward, Clark, & Heidrich, 2009). Also, the Minority Stress framework (Meyer, 1995; Meyer, 2003) provides a firm explanation for the negative health and mental health outcomes that are in responses to social stressors resulting from social minority status identities. In response to the gap in the literature with Multiracial individuals and the areas addressed above, a clear relationship will be described to assist in uncovering the mental health disparity of Multiracial individuals. Data will be provided to detail the counseling utilization of POC. In this manuscript, a review of the psychocultural constructs of racial identity, discrimination, and self-stigma of mental health services and the effects they have on Multiracial individuals' intentions to seek counseling will

be examined. Implications for Mental Health Providers and Counselor Educators working with and focused on increasing the use of counseling for Multiracial individuals will be discussed.

Mental Health Disparity

Access and underutilization of mental health services for POC are identified as a public mental health concern (Office of Minority Health, 2004; SAMSHA, 2017; UHHS, 1999), and according to the 2003 President's New Freedom Commission on Mental Health report, mental health is essential to overall health especially for POC. Only half of those with severe mental illness will seek treatment (President's New Freedom Commission on Mental Health, 2003). These findings were supported by the Substance Abuse and Mental Health Association's (SAMSHA) 2017 report where 29.8 percent for Blacks and 27.3 for Hispanics with severe mental illness reported using psychological services that encompassed inpatient, outpatient, and pharmaceutical drugs. From 2008 to 2012, the National Survey for Drug Use and Health data described the mental health utilization for individuals without mental illness of racial and ethnic groups in the U.S. aged 18 years or older. Their findings revealed that Multiracial individuals disclosed utilizing mental health services within the last year at a higher rate (17.1 percent) than any other racial group (White 16.6% and American Indian or Alaskan Native 15.6 percent, Black 8.6 percent, Hispanic 7.3%, and Asian 4.9%). Multiracial groups also reported using outpatient services at a higher rate compared to other groups (8.8% for multiracial groups compared to 7.8 for White adults and 4.7 for Black adults). Furthermore, Multiracial individuals sought mental health services at a higher rate than their counterparts even when accounting for age, gender, or socioeconomic status (SAMSHA, 2017). Although these findings showcase increased use of counseling for Multiracial individuals compared to other racial and ethnic groups, the

percentages are low and do not provide a full description of what factors impact the use of counseling services nor do they specify which racial groups the multiracial group included.

Factors impacting counseling utilization are poverty, cost of insurance, and psychocultural factors (Office of Minority Health, 2004; SAMSHA, 2017; UHHS, 1999). More specifically, the psychocultural factors such as stigma, discrimination, and ethnic/racial identity of POC affect POC's attitudes toward counseling services. While investigating attitudes related to seeking therapy, studies by Loya, Reddy, and Hinshaw (2010) and Masuda et al. (2012), revealed that POC who experienced psychological distress held more negative attitudes toward seeking counseling when compared to their White counterparts. These findings showcase the influence that attitudes and beliefs play in POCs counseling utilization; however, there is limited information about how attitudes specifically impact Multiracial individuals' willingness to seeking counseling services. Most researchers who explored intentions or willingness to seek counseling focused on monoracial POC's attitudes and willingness to seek counseling (Barksdale & Molock, 2009; Cheng, Sevig, & Kwan, 2013), yet, there is a paucity of research that assesses Multiracial individuals use and attitudes related to psychological services and other factors that might impact their counseling utilization. Additionally, SAMSHA's (2017) data findings are promising that Multiracial individuals may view mental services differently than other POC, and there this a dearth of research assessing their use and attitudes related to mental health services which support the need for this study. In the following sections, this author will examine psychocultural factors that impact the use of mental health services.

Racial Identity

Researchers assert that POC's racial identity influences their counseling use (Ayalon & Young, 2005; Ward, Clark, & Heidrich, 2009; Yasui, Hipwell, Steep & Keenan, 2015, Zuvekas,

Fleishman, 2008). According to Ayalon and Young, (2005), African Americans reported using religious services instead of counseling services more than their White counterparts. Asian Americans were less likely to seek counseling services when in distress compared to White Americans (Kim & Zane, 2016). Most of the studies used demographic self-reported surveys to assess the roles in which race played in counseling utilization, but there is a limited amount of research that evaluated the role that racial identity integration plays in counseling utilization. In the studies that did assess racial identity, they identified a connection between the type of racial identity formation participants had and its impact on mental health use. Racial identity formation is the process by which individuals assess their belief systems, feelings of connectedness, and relatability to a cultural group's traditions and values. As a result of this connectedness, (Phinney, Jacoby, & Silva, 2007; Phinney & Ong, 2007; Sellers, Rowley, Chavous, Shelton, & Smith, 1997), individuals will either form a racial identity that is congruent with that racial identity (integration) or incongruent.

Richman, Kohn-Wood, and Williams (2007) explored the relationship between discrimination, racial identity integration, and mental health use of 1,000 Black and White individuals. To assess racial identity integration, the researchers developed a measure with two constructs of identity to evaluate the influence of identity and integration on mental health utilization. One construct within the identity integration was feelings of closeness to others within one's racial group, and another construct was centrality. Centrality described participants' perceived importance and meaning of their racial identity. Findings revealed that Blacks within the study who rated high on centrality were more likely to underuse mental health services. Mainly, Blacks who rated high on centrality were more likely to feel a sense of meaning and pride within their Black identity and were more likely to underuse mental health services

compared to their White counterparts. Centrality or cultural connectedness and meaning is grounded in one's cultural traditions which connect to cultural mistrust or stigma that affects counseling use (Richman, Kohn-Wood, & Williams, 2007).

Similarly, Cheng, Kwan, and Sevig (2013) explored the impact of ethnic identity and discrimination on self-stigma of psychological services of 260 African Americans, 166 Asian, and 183 Latino participants, and found that ethnic identity affected the underuse of mental health services. African American and Latino Americans who scored high on ethnic identity were less likely to use counseling, as compared to Asian American participants. These findings suggest a need to understand further the role of racial/ethnic identity integration on mental health use and this is especially true for Multiracial individuals' racial identity that is complex and challenges social constructs of racial identity.

Before discussing the definition of Multiracial individuals and Multiracial identity development, an understanding of both race and ethnicity must be described. The U.S. Census Report (2013) defines race as a general social construction of groups of people within the U.S.; these racial groups consist of those who share "social definition of race" and is not limited to heredity, for example, phenotypical features: skin color, hair, facial features (Citro, 2012). Whereas, ethnicities describe the individuals' social experience: (i.e., their culture, traditions, language, and nationality) that connects groups of people (Citro, 2012). Multiracial identity is having two racial identities or ethnic identities. The United States government census has created six racial identity groupings for racial identification (White, Black or African American, American Indian and Alaska Native, Asian, and Native Hawaiian and Other Pacific Islander, and Two or More Races) of which most individuals in America use to self-identify themselves (Jackson, Yoo, Guevarra & Harrington, 2012; Shih & Sanchez, 2009). The first five will be

referred to when discussing the multiple racial makeups of Multiracial individuals. Also, along with prior research, the use of Hispanic/Latino and non-Hispanic/Latino heritages (e.g., Mexican and Black, Puerto Rican and White) will be included when discussing racial groups and the racial/ethnic makeup of Multiracial individuals (Jackson et al. 2012). When conceptualizing the complexities of racial identification that an individual of mix racial background must navigate through as an adult, it is of significant interest to investigate the factors that may impact counseling use for Multiracial individuals. Multiracial identity models (Henriksen, 2013; Poston, 1990; Renn, 2008; Root, 2003;) explain the different psychosocial effects of selecting a Multiracial identity that may produce psychological distress resulting from discrimination or monoracism (Nadal & Johnston, 2010). Poston (1990) proposed a linear model of identity development for Biracial individuals that described Biracial identity as an adhering to the social characterization of their racial identity as a result of physical characteristics. Multiracial individuals will select identities from which they physically represent. Although this is an early Biracial identity model, it addresses the role in which social constructs of race impact Multiracial individuals. Whereas, in Root's (1992b) model, she helps frame the racial tension Multiracial individuals experience related to racial discrimination and internalized racism and propose four ways in which Multiracial individuals navigate toward an integrated identity. As a result of the findings of monoracial POC and the role of identity formation plays in their counseling use, it is of interest in this study to assess the influence of Multiracial identity integration and its effect on counseling use.

Discrimination

Racial discrimination is a significant contributor of psychological distress for POCs (Carter Forsyth, 2010; Richman, Kohn-Wood, & Williams, 2007). Racial discrimination includes

the harmful behaviors or acts against people who hold minority racial status based on negative or demeaning stereotypes, values, and attitudes about a racial group(s) (American Psychological Association [APA], n.d.). As a reaction to racial discrimination experienced or observed, POC are susceptible to psychological distress, such as depression, anxiety, and isolation (Barksdale & Molock, 2009; Carter & Forsyth, 2010;). POCs who experience psychological distress are seeking psychological services at lower rates than their White counterparts (Office of Minority Health, 2004, Hogan, 2003; Kim & Zane, 2016; Yasui, Hipwell, Stepp, and Keenan, 2015; SAMSHA, 2017). Moreover, POC who experienced psychological distress as a result of discrimination sought counseling at a lower rate when compared to their White counterparts (Abe-Kim, Takeuchi, Hong, Zane, Sue, Spencer…. Alegría, 2007; Carter & Forsyth, 2010; Richman, Kohn-Wood, & Williams, 2007; Ward, Clark & Heidrich, 2009; Cook et al.2012; Zuvekas & Fleishman, 2008).

Similarly, to POC, Multiracial individuals experience psychological distress as a response to discrimination (Franco & O'Brien, 2018; Giamo, Schmitt, & Outten, 2012; Jackson, Yoo, Guevarra, & Harrington, 2012; McDonald et al., 2019). As a result of having an integrated Multiracial identity that challenges the status quo and disrupts the construction of race, people from mixed-race backgrounds experience a multitude of discrimination (Johnston & Nadal, 2010). Multiracial individuals experience psychological distress, such as anxiety, stress, and depression (Jackson et al. 2012). In Giamo and colleagues' (2012) study, the experience of discrimination for 252 Multiracial individuals decreased overall life satisfaction. Franco and O'Brien (2018) developed a Multiracial identity invalidation scale that assessed 542 Multiracial individuals' experiences of racial invalidation, a form of discrimination Multiracial individuals experience. The researchers' findings revealed that racial invalidation directly related to the

participants' experiences of psychological distress (depressive symptoms, cultural homelessness, self-esteem, and loneliness). Seeing that discrimination for all POCs, even Multiracial individuals, increases the likelihood of psychological distress and that discrimination decrease use of counseling services for POCs, it is worth investigating the role discrimination may have on Multiracial individuals use of mental health services. These findings further support the need to not only provide psychological support for Multiracial individuals but also assess their mental health utilization.

Self-Stigma

Minority stress theory provides further explanation for minority mental health and the impact of stigma and other sociological stressors. Meyer's (1995; 2003) minority stress theory provides further support for how racism and discrimination significantly impact POCs physical health and mental health. Minority stress posited that individuals with a minority status identity are exposed regularly to distal and proximal stressors. The distal stress represents stressors that are external and objective being that they are not in direct relation to a minority identity. Examples of distal stressors are prejudices, discrimination, and stigma. Proximal stress is noted as the internal psychological response individuals endure as a result of the distal stressors. Proximal stressors are described as concealment of minority identity (e.g., sexual orientation), hypervigilance, and internalized stigma. Although minority stress has been primarily used to explain the stressors that sexual minorities endure and have been found to impact counseling utilization (Meyer, 1995; Meyer, 2003); some studies have begun to investigate the effect minority stress may have on other marginalized groups. Notably, researchers have begun to uncover the impact of minority stress on African Americans and their mental health (Pieterse, Todd, Neville, & Carter, 2012). Pittman, Cho Kim, Hunter, and Obasi (2017) investigated 145-

second generation Black Americans' drinking behaviors and exposure to racial stressors by looking through the minority stress framework. The minority stress model was supported in this study, race-related stress and acculturative stress related to higher risky drinking behaviors. Therefore, if POC are exposed to distal and proximal stressors, it is reasonable to assume that Multiracial individuals will experience similar prejudices and discrimination due to monoracism, in addition to racism, which will impact their seeking health services (e.g., counseling). Monoracism is systemic tool or product monoracial on paradigms or race which assist with the oppression and exclusion of multiracial individuals and language that acknowledges their existence in policy, education, and society as a whole (Johnston & Nadal, 2010).

In response to the Surgeon General report (UHHS, 1999) about the effects of stigmatization on the use of mental health for POCs (UHHS, 1999). Teresa Chapa, the Director of the Office of Minority Health, stated in a report entitled Mental Health Services in Primary Care Settings for Racial and Ethnic Minority Populations (2004), stigma is a result of "a legacy of racism and discrimination, leading to the distrust of health and mental health professionals." Since these reports, other researchers have identified that stigma is related to POC's underutilization of mental health (Barksdale & Molock, 2009; Cheng, Kwan, & Sevig, 2013; Hogan, 2004; Masuda, Anderson, & Edmond, 2012) aside from other factors, such as poverty and cost of insurance, (SAMSHA, 2017). Self-stigma of mental health is one of the common factors that contribute to the decreased use of counseling services (Office of Minority Health, 2004). However, stigma was not found to be a top cause of mental health disparities for POCs in SAMSHA's 2017 report.

Researchers have made tremendous efforts to investigate how stigmatizing beliefs directly impact the use of counseling services. David Vogel has extensively researched self-

stigma of seeking help and has defined it as the "stigma associated with seeking mental health services, therefore, is the perception that a person who seeks psychological treatment is undesirable or socially unacceptable" (Vogel, Wade, & Haake, 2006, p. 325). In his study accessing the validity of the Self-stigma of Seeking Help Scale, Vogel and his colleagues' analysis suggested that there are significant correlation between the stigma scale, intentions to seek counseling, apprehension when disclosing personal information to a therapist and negative attitudes and beliefs toward counseling when mental health stigma increased. According to Cheng et al. (2013), those who scored high on self-stigma of seeking psychological services would be less likely to seek counseling services when experiencing psychological distress. In this study, self-stigma negatively related to ethnic identity (Cheng et al., 2013). Cheng and colleagues' (2013) findings shed light on the impact self-stigma has on the use of counseling for POCs, even when experiencing psychological distress.

Masuda et al. (2012) assessed 221 African American students' mental health stigma and self-concealment and their effect on attitudes toward seeking psychological services. Participants who rated high on mental health stigma and self-concealment were more likely to have negative attitudes toward seeking psychological services. In other words, participants who had stigmatizing beliefs and felt the need to conceal personal information about themselves were more like to have negative attitudes about counseling utilization. At the time of this literature review, the author identified only one study on Multiracial individuals' counseling attitudes. Constantine and Gainor (2004) investigated 62 Biracial (Black and White) college women's attitudes toward counseling and depressive symptom effect on help-seeking behaviors. They found that those who had a positive attitude toward counseling and higher levels of depression were more likely to seek out mental health services.

This literature review further highlights the influence of stigma or attitudes on the actual use of counseling services for POC. Although there is an abundance of research related to the role stigmatizing beliefs of mental health services that affect the use of counseling for POC, there is a dearth of research addressing how stigma plays a role in mental health use of Multiracial individuals. The goal of the study is to address this gap in the literature and assess the impact stigma may have on Multiracial individuals counseling use.

Conclusion and Implication

Researchers have concluded that POC underuse counseling services as a result of psychocultural factors, such as racial identity, discrimination, and stigma of mental health services that is further supported by the minority stress framework. It is plausible that these same factors will have similar effects on Multiracial individuals. Psychocultural factors: ethnic identity (Cheng, et al, 2013; Richman, Kohn-Wood, & Williams, 2007), discrimination (Carter & Forsyth, 2010; Cheng, et al, 2013; Richman, Kohn-Wood, & Williams, 2007), and stigma (Mausda, et al., 2012; Ward, Clark, & Heidrich, 2009) have been found to impact the underuse of mental health services for POC. Multiracial individuals' racial identity integration represents some of the primary forms of racial identity development similar to racial identity development of POC, especially for monoracial individuals with bicultural identities (Cheng and Lee, 2009). Multiracial individuals either reach a level of full identity integration of accepting their racial identity or experience not feeling connected or are in constant conflict with their racial identity (Cheng and Lee, 2009). If the type of racial identity integration predicts the use of counseling for POCs, then it is fair to say Multiracial individual's racial identity integration will have the same response. Additionally, if the experience of racial discrimination and stigmatizing beliefs of

mental health in facts impedes on POCs use of psychological services than it is plausible to believe the same will be true for Multiracial individuals and warrants further investigation.

More research is needed to have a better understanding of how psychocultural factors such as racial identity, discrimination, and stigma play a role in the use of counseling for Multiracial individuals. By developing awareness and meeting the needs of Multiracial individuals within counseling, professional counselors can strengthen client rapport, therapeutic interventions, counseling outcomes for Multiracial individuals. In the field of counseling, this manuscript will assist professional counselors and counselor educators by finding ways to serve this population better and advocating on behalf of this group but also further supporting counseling competence, training and supervision. The field of counseling has made strides toward developing counseling competencies for working with the Multiracial populations (Kenney, K. R., Kenney, M. E., Alvarado, S. B., Baden, A. L., Brew, L., Chen-Hayes, S.,...Singh, A. A., 2015) and yet there is paucity of research to understand what psychocultural factors may affect counseling use for this population. Once the impact of those factors can be identified, the better prepared the counseling field can be to strengthen outreach programs further and increase counseling retention for Multiracial individuals. There is an apparent need to improve training to prepare counselors working with Multiracial individuals effectively. By doing so, we will assist these individuals in achieving more positive life outcomes (Henriksen & Maxwell, 2016). Finding how the psychocultural factors for Multiracial individuals impact their counseling use will provide counseling outreach and effective interventions for working with these populations.

At the time of this study, no quantitative studies have investigated factors that influence Multiracial individuals' intentions to seek counseling. Stigma, discrimination, and racial identity

integrations is a part of the lived experience of POC and Multiracial individuals. Moreover, these three factors are shown to affect mental health utilizing for POCs, and it is worth investigating how racial identity integration, discrimination, and stigma impact intentions to seek counseling. Specifically, future studies should examine the relationship between Multiracial identity integration, discrimination, self-stigma of seeking help, and intentions to seeking counseling.

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2 ASSESSING THE IMPACT OF PSYCHOCULTRAL FACTORS ON BIRACIAL INDIVIDUALS' WILLINGNESS TO SEEK COUNSELING

The Biracial populations represent 6.9% (9 million) of the U.S. population (Census, 2010), and those numbers are expected to triple by 2060 (Pew Research, 2015). Individuals identifying with two or more races are vastly diverse in racial makeup and identity. One commonly used term is Biracial, which refers to those solely identifying with two racial/ethnic identities. Whereas, Multiracial identity refers to those with two or more racial identities. Within this study, the author will use the term Biracial when discussing those with a mixed race background, unless describing studies with a Multiracial participant pool the term Multiracial will be used. Literature on the Biracial population within the counseling field has been surprisingly stagnant despite the continual growth of the Biracial population and the acknowledgment of this group as an official U.S. racial group as shown by the adding of the "Two or More Races" category to the 2000 U.S. Census. Evans and Ramsey (2015) conducted a content analysis of all studies about Biracial individuals published in counseling journals from 1991 to 2013. During their investigation, the authors identified, between 1991 to 2000 only five publication, despite the groundbreaking addition to racial categorization within the Census survey. Then from 2000 to 2013, five additional articles were published about this population, totaling ten publications by 2013 (Evans & Ramsey, 2015). The majority of the studies addressed the impact of racial identity formation (Herring, 1995 Jourdan, 2006; Suyemoto, 2004) or the psychological distress Biracial individuals experience (Moss & Davis, 2008; Nishimura, 1998; Robison, 2001; Smart, 2010; Williams, 1999). Since 2013, only one study about Biracial individuals (McDonald, Chang, Dispenza, & O'Hara, 2019) was identified within a counseling journal. Additionally, the development of the first counseling specific *Competence for Working*

with the Multiracial Population (Kenney, et al., 2015) was developed to increase counselors' awareness and knowledge when working with this population. The presences of literature solely focused on the Biracial population is promising, yet, there is a dearth of research addressing counseling utilization of Biracial individuals, with the exception to Constantine and Gainor's (2004) study that assessed Biracial college women's attitude toward psychological services.

In the ground-breaking 1999 report by the Surgeon General, people of color (POC) were reported to underutilize counseling services. As a result of this concern, other government agencies within the U.S. Department of Health and Human Services (UHHS), such as, the Office for Minority Health (2004), and Substance Abuse and Mental Health Administration (SAMSHA, 2017) have contributed to the efforts of increasing public awareness about the underuse of mental health services and possible barriers. Barriers identified in these reports for POC included poverty, cost of insurance, mental illness, and psychocultural factors. Most recently, data analyzed by SAMSHA (2017) from the National Survey for Drug Use and Health report captured for the first time by a government agency Biracial individuals' counseling utilization. The findings revealed Biracial individuals reported using psychological services at a higher rate (17.1 percent) than their monoracial counterparts (American Indian or Alaskan Native 15.6 percent and White 16.6 percent, etc.) even when accounting for age, gender, and socioeconomic status. This report is encouraging with the previous data about POC's underutilization of counseling. However, it is essential to note that these percentages are low, and the data is limited to self-reports of use and, most important, information related to barriers to counseling use is missing. As a result, research investigating POC's counseling utilization and factors that may impact their psychological seeking behaviors will be discussed. Given the lack of research of Biracial individuals and counseling utilization, the author will build on the research of POC and

when appropriate, apply to Biracial individuals. By unpacking the mental health disparity of all POC, it will help frame the proposed mental health disparity Biracial individuals experience. This framing is done by connecting and comparing racial identity integration, racial discrimination, and mental health stigma of other POC to Biracial individuals. If psychocultural factors influence mental health use for POC, then it is plausible to assume that Biracial individuals will be affected similarly. Within this study, the role of Biracial identity integration, discrimination, and self-stigma of seeking help will be examined to understand Biracial individuals' intentions to seek counseling services.

Counseling Utilization

POC's intentions to seek counseling have been widely investigated, especially within the literature addressing psychocultural barriers, specifically within racial identity (Ayalon & Young, 2005; Barkdale & Molock, 2009; Carter & Forsyth, 2010; Kim & Zane, 2016; Masuda, Anderson, & Edmonds, 2012; Richman, Kohn-Wood, & Williams, 2007; Ward, Clark, & Heidrich, 2009; Yasui, Hipwell, Stepp, & Keenan, 2015), discrimination, (Carter & Forsyth, 2010; Richman, Kohn-Wood, & Williams, 2007; Yasui et al., 2015) and stigma (Barksdale & Molock, 2009; Masuda, et al., 2012; Ward et al., 2009). Cheng, Kwan, and Sevig (2013) investigated self-stigma of others for seeking psychological services and factors such as psychological distress and psychocultural (ethnic identity, other group orientation, and perceived discrimination) variables that may affect those perceived stigmatizations. Findings from the study suggested that participants' (260 African American, 166 Asian American, and 183 Latino American,) ethnic identity had a negative relationship with self-stigma of seeking help for some of the racial groups. African Americans who rated high on racial centrality, feelings of closeness, and a sense of meaning to one's identity, were less likely to seek counseling. As for African

Americans who rated higher on feelings of closeness to others within their racial group were more likely to have fewer stigmatizing beliefs and seek out counseling more. These findings were not supported by the Latino American and Asian American participants. This current study is utilizing the Cheng and colleagues (2013) research as a guide to investigate the psychocultural barriers to counseling use for Biracial individuals and will be used within each section to support the rationale for this study.

POC are less likely to seek counseling services as compared to their White counterparts (Abe-Kim, Takeuchi, Hong, Zane, Sue, Spencer….. Alegría, 2007; Carter & Forsyth, 2010; Cook et al.2012; Richman et al, 2007; Ward, Clark, & Heidrich, 2009; Zuvekas & Fleishman, 2008). SAMSHA (2017) reported average estimates of seeking mental health services within the last year, for White individual's 16.6 percent reported seeking mental health services which are significantly higher than Asian Americans at 4.9 percent and Blacks at 8.6%. American Indians or Alaskan Natives at 15.6 percent was comparable but still lower than White Americans. Most surprising, those identifying with Two or More races reported seeking counseling at 17.1 percent, which was .5 percent higher than their White counterparts. Although these findings are compelling, we do not have a clear understanding of the factors that encourage counseling use for this population. Additionally, we do not know what constituted the specific racial make-up of the participant who selected two or more races.

The Office of Minority Health within the Department of Health and Human Services (2004) thoroughly documented the mental health disparities for POC. The report identified other barriers to seeking services, such as poverty, access to insurance, and primary care. In Abe-Kim and colleagues' study (2007) that assessed the use of mental health-related services of Asian immigrants and Asian Americans, of the 2,095 participants, only 8.6% sought mental health-

related services. Another study evaluated 219 African American college students and the influence of culturally specific factors, such as negative peer and family norms on their intentions to seeking counseling. Participants who perceived negative attitudes or stigmatizing beliefs of family and peers about mental health services were less likely to seek mental health services (Barksdale & Molock, 2009). These findings provide insight into the cultural factors and stigma that impact POC's use of counseling.

Additional factors such as discrimination experienced by POC that produced psychological distress, (i.e., anxiety, stress, and fear) have been identified to affect self-reported health (Brondolo, Hausmann, Jhalani, Pencille, Atencio-Bacayon, Kumar, … & Schwartz, 2011). Studies have shown that Biracial individuals have mirroring effects as a result of being stereotyped or experiencing discrimination, such as racial microaggression and racial invalidation (Johnston & Nadal, 2012; McDonald et al., 2019). Further research is needed to understand how the psychocultural constructs affect Biracial individuals counseling use.

Racial Identity

Racial or ethnic identity is a strong predictor of counseling utilization (Ayalon & Young, 2005; Cheng et al.2013; Richman, Kohn-wood & Williams, 2007). Racial or ethnic identity (integration) is a multifaceted construct that entails the awareness, knowledge, feelings of closeness and belonging, social attachment, sense of pride and meaning toward one's racial or ethnic cultural traditions and values (Phinney, Jacoby, & Silva, 2007; Phinney & Ong, 2007; Sellers, Rowley, Chavous, Shelton, & Smith, 1997). Richman and colleagues (2007) assessed the effect of discrimination and ethnic identity on mental health utilization of 1,000 Black and White participants. Researchers within this study discovered mix findings related to racial identity integration for their Black participants. For instance, Black participants who felt more connected

to other Black individuals (e.g., referred to as regard; feeling oneness within a group) were more likely to seek psychological services. In contrast, Black participants who felt a sense of closeness and meaning to their racial identity (e.g., centrality; feeling that one's true self is seen and experienced through their racial identity) were more likely to decrease their use of counseling services. Cheng and colleagues (2013) did not find that the type of racial identity integration influenced Asian American and Latinos beliefs about seeking psychological help. However, for their African American participants, those who had a high racial identity integration were more likely to increase their use of counseling services. Similarly, Ramos-Sanchez and Atkinson (2009) reported that in a sample of 262 Mexican American college students, the participants with stronger connectedness to their cultural values (i.e., racial identity integration) had more favorable attitudes toward help-seeking. These findings further support the need to investigate the influence of racial identity integration on individuals' attitudes and behaviors about counseling use.

Biracial individual's identity integration, because Biracial individuals are integrating two cultural backgrounds, may be more complex than monoracial individuals. For Biracial individuals, their identity integration is fluid because their racial identity is not fixed but contextual. As a result, Biracial individuals' cultural values and connectedness to their racial identity at times can encompass the two racial groups. Cheng and Lee (2009) developed the Multiracial Identity Integration Scale, which assesses racial identity formation of Multiracial individuals (those identifying as Biracial or Multiracial). Multiracial identity integration consists of two distinct dimensions of conflict and distance. High scores on conflict signify that the values and norms of their multiple cultural identities contradict one another. High scores on racial distance indicate that the multiple identities are separate from one another. Individuals

with lower scores on distance and conflict, experience higher identity integration and perceive their multiple identities as compatible. The type of racial identity formation, such as an integrated or conflicted identity has been found to be impactful to Biracial individuals lived experience. For example, scholars found having an integrated Multiracial identity acted as a buffer when experiencing increased psychological distress due to encountering discrimination (Jackson, Yoo, Guevarra, & Harrington, 2012; Lou & Lalonde, 2015; Lusk, Taylor, Nanney, & Austin, 2010). Experiencing distance or conflict when trying to incorporate the multiple racial identities into one's self-concept are linked to psychological outcomes (Cheng & Lee, 2009; Jackson et al., 2012; McDonald et al., 2019). These findings reveal the type of racial identity for Biracial individuals can be both a protective factor and a risk factor to psychological outcomes, which is similar to the findings stated above for POC. Moreover, POC who despite experiencing psychological distress as a result of discrimination were less likely to seek counseling, and therefore, it is essential to investigate this possible phenomenon for Biracial individuals. Additionally, there is a lack of research examining the role that Biracial individuals' identity integration's impact on counseling use.

Discrimination

Another area to consider is the role that racial discrimination and stereotypes play in counseling utilization (Carter & Forsyth, 2010; Kohn-Wood & Hooper, 2014; Richman et al, 2007; Yasui et al, 2015). Studies have identified that POC who experience discrimination are more likely to exhibit signs of psychological distress (Brondolo, et al., 2011; Carter et al., 2013; Franco & O'Brien, 2018). Carter and Forsyth (2010) investigated the experience of emotional and psychological reactions to encounters of discrimination and their help-seeking behaviors of 260 participants of which 52 percent identified as Black, 11 percent identified as Latino, 12

percent identified as Asian American, 4 percent identified as American Indian, and 6 percent identified as Biracial individuals. Participants were asked to select from a checklist of 17 helpers from whom they would seek help. Fifty-seven percent of the participants reported seeking help to deal with their experience of discrimination from a friend or family, less than ten percent reported being willing to seek counseling from a mental health professional. Latino and Asian American participants reported seeking psychological services at a higher rate than the Black and Biracial participants.

Biracial individuals, too, are exposed to racial discrimination such as microaggression (What are you?), and racial invalidation ("You're not Biracial. If your dad is Black, then you are Black."; Franco & O'Brien, 2018; Johnston & Nadal, 2012; McDonald et al., 2019). Knowing the impact of discrimination for both POCs and Biracial individuals and the underuse of counseling for those POCs, it is essential to investigate the role discrimination plays in Biracial individuals mental health use to better serve this population.

Self-Stigma

Self-stigma is another predictor of counseling underutilization for the general populations, as well as, for POC (Cheng et al.2013; Masuda, Anderson, & Edmonds, 2012; Mishra, Lucksted, Gioia, Barnet, & Baquet, 2009; Office of Minority Health, 2004, Ward, Clark, & Heidrich, 2009). Vogel and his colleague (2006, p. 325) defined, self-stigma of psychological seeking behaviors as "stigma associated with seeking mental health services, therefore, is the perception that a person who seeks psychological treatment is undesirable or socially unacceptable." Tresa Chapa, the director of the Division of Policy and Data, stated in the Mental Health Services in Primary Care Settings for Racial and Ethnic Minority Populations, UHHS department issued brief:

> Yet stigma continues to be a major barrier to seeking out care. ….. In addition to shame, minorities often feel the legacy of racism and discrimination, leading to the distrust of health and mental health professionals. Feelings of stigma, discrimination, and mistrust of authorities preclude individuals in need from seeking out and receiving the help and treatments that can lead them to recovery (Office of Minority Health, 2004, p.10).

Minority stress theory provides further explanation for minority mental health and the impact of stigma and other sociological stressors. Meyer's (1995, 2003) minority stress theory offers additional support for how racism and discrimination significantly impact POCs physical health and mental health. Minority stress posited that individuals with a minority status identity are exposed regularly to stressors (i.e., distal and proximal). Distal stress represents stressors that are sociocultural antisocial behaviors that are based on stereotypical thinking and grounded in prejudices. Prejudices, discrimination, and stigma are some example of this form of stress. Proximal stress is noted as the internal psychological response individuals endure as a result of the distal stressors. Proximal stressors for sexual monitories consist of concealment of minority identity (e.g., sexual orientation), hypervigilance, and internalized stigma. Most research addressing the minority stress framework is focused on sexual minorities (Meyer, 1995; 2003). Researchers studying race are gradually adopting the minority stress framework to describe the stress people from marginalized backgrounds are exposed to on a routine basis (Pieterse, Todd, Neville, & Carter, 2012). For example, Pittman, Cho Kim, Hunter, and Obasi (2017) investigated 145-second generation Black Americans' drinking behaviors and exposure to racial stressors by looking through the minority stress framework. The study's findings supported the minority stress model, race-related stress, and acculturative stress related to higher risky drinking behaviors. Biracial individuals are not only exposed to racism but monoracism, which can result

in discrimination. Monoracism is a systemic tool or product that perpetuated the monoracial paradigms or race superiority which assist with the oppression and silencing of Biracial individuals and language that acknowledges their existence in policy, education, and society as a whole (Johnston & Nadal, 2010).

Similarly, to POC, Biracial individuals' exposure to discrimination due to their minority identity and other intersecting identities (double marginalization occurring) will heighten proximal stressor. It is fair to conclude that Biracial individuals will be at risk to the similar negative racial attitudes due to monoracism, in addition to racism, that will impact their counseling utilization. Moreover, the proximal stressors transform into internal narratives about representations of "rightness" when distal stressors arise, which will have an impact on proximal stressors (internalized beliefs). These personal beliefs of "rightness" or how someone is a deviant from social norms are, in fact, self-stigma.

A widely investigated topic as it pertains to mental health stigma is POC's underuse of counseling. For instance, Masuda et al., (2012), examined help-seeking attitudes, mental health stigma, and self-concealment of 163 African American college students and found a negative relationship between mental health stigma and help-seeking attitudes. Cheng and colleagues (2013) explored the relationship among psychological distress, ethnic identity, other group orientation, perceived discrimination and self-stigma of seeking psychological help among three groups (African Americans, Asian Americans, and Latino Americans). For all three groups, increased levels of psychological distress predicted higher levels of self-stigma of seeking psychological help. A strong centralized ethnic identity in the African American and Latino group decreased the level of self-stigma of seeking psychological help (Cheng et al., 2013). At the time of this literature review, the researcher only found one study that explored the attitudes

and beliefs of psychological use for Biracial individuals. Constantine and Gainor (2004) found that favorable counseling attitudes resulted in increased help-seeking behaviors in 61 Biracial college students. This study provides the connection of how mental health values and beliefs affect the perception of counseling and possible utilization. These studies further address how attitudes or self-stigma of seeking psychological services and ethnic identity impacts the mental health care of POCs.

The possible lack of interest in attending mental health services in the growing population of Biracial individuals is concerning and requires a fuller understanding of these groups barriers to seeking psychological services. Self-stigma connects to higher levels of discrimination and ethnic identity in POC; therefore, it is essential to examine the effect of self-stigma of seeking psychological help in Biracial individuals. For POCs, racial discrimination and self-stigma of mental health are interwoven experiences that are a byproduct of the legacy of racism POCs experienced within the health and mental health fields. Therefore, self-stigma specifically looking at counseling, may be an essential factor to consider as a moderator for intentions to seek counseling.

The researcher chose self-stigma as a moderator, because Biracial individuals similar to those with other marginalized identities (e.g., sexual minorities, monoracial individuals) are exposed to stigma and discrimination which makes them more susceptible to psychological distress (i.e., Minority Stress theory; Jackson et al., 2009; McDonald et al., 2019). Biracial identity has only been acknowledged as a racial category for about 20 years. Therefore, the majority of individuals who are older than 20 years may still adhere to a single racial identity superimposed on them by the social constructs of race (Pew Research, 2015). As a result, these individual's worldview is dualistic and focused on "rightness" of social norms because they are

fearful of being perceived as social deviants. These indoctrinated beliefs are consistent with the impact self-stigma has on individuals who adhere to social expectation (Vogel et al., 2006).

Biracial individuals who are more likely to experience identity conflict or distance are more susceptible to stigmatizing beliefs as evidenced by their need to keep their racial identities separate (i.e., distance) as a way to avoid social isolation or ridicule from others. However, Biracial people with an integrated racial identity, in particular, have a unique ability to understand the "in between" or ambiguity between social space. This understanding and perspective are directly shown through navigating their racial identity identification (Root, 2002) and especially true for those with an integrated racial identity (Jackson et al., 2012; Miville, Constantine, Baysden, & So-Lloyd, 2005). Therefore, if those with a more integrated Biracial identity have a more flexible view around the "rightness" of social norms, they may be more likely to seek counseling. The opposite would be true for those with a more conflicted or distant Biracial identity, they are more likely to heed to the rigid belief of "rightness" which would make them susceptible to internalized beliefs (i.e., self-stigma). It would make sense that being able to live in the grey space and externalize reasons for seeking counseling may help Biracial people enter these predominantly White spaces. Counseling is often seen as a "White People thing," but again Biracial people can live in the "grey" and feel less stigma entering those spaces when they have a full integrated Biracial identity or experience discrimination because they have more grey space tolerance. Again, the opposite would be true for those with a less integrated racial identity (conflict or distance).

Present Study

This study assessed the roles that racial identity, discrimination, and self-stigma of seeking psychological services had on Biracial individuals' counseling utilization. The following

research questions were investigated in this study: Q1) What are the relationships among Biracial identity integration, discrimination, self-stigma of seeking help, and intentions to seek counseling? ha) There will be no significant relationship between Biracial identity integration, discrimination, self-stigma of seeking help, and intentions to seek counseling in Biracial individuals. Q2) Do Biracial identity integration, discrimination, and self-stigma of seeking help predict intentions to seeking counseling in Biracial individuals? hb) Biracial identity integration, discrimination, and self-stigma of seeking help will not be a significant predictor of intentions to seek counseling. Q3) Will self-stigma of seeking help moderate the relationship between Biracial identity integration and intentions to seek counseling? hc) Self-stigma of seeking help will not moderate the relationship between Biracial identity integration and intentions to seek counseling? Q4) Will self-stigma of seeking help moderate the relationship between discrimination and intentions to seek counseling? hd) Self-stigma of seeking help will not moderate the relationship between discrimination and intentions to seek counseling?

Method

Participants

This study investigated Biracial individuals who racially identify with two racial or ethnic identities (e.g., African American/Black, Asian American/ Pacific Islander, Hispanic/ Latinx, Native American, and White/Caucasian). A target sample size of 68 was identified based on an a priori power analysis using G*Power with a medium effect size of .15, an alpha of .05, and a power of .8. The G*Power 3.1 program was used to identify the suggested sample size required for this study (Faul, Erdfelder, Buchner, & Lang, 2009). However, Hayes (2013) recommends 200 participants when conducting a moderation analysis.

Participants were recruited through Amazon Mechanical Turks (M*Turks). Two hundred and two people participated in this study (age: $M = 29.85$, $SD = 7.92$, range 18-60 years). Participation was on a volunteer basis, and consent was given by each participant regarding the completion of the online survey. The sample included 124 individuals who identified as female (61.4%) and 78 individuals who identified as male (38.6%) with twelve people from this group identifying as transgender.

All 202 participants described themselves as Biracial. The largest group consisted of 67 participants (33.2%) who identified as Hispanic and White. The second largest sample group included 36 participants (17.8%) who described themselves as Black and White. Those identifying with Black and another race or ethnicity (Hispanic identity) represented 31 participants (15.4%). Thirty-six participants (17.8%) identified with White and another race (e.g., either Asian or Native). Thirty-two participants of the remaining sample (15.8%) identified as Hispanic and Asian (5.9%) and Hispanic and Native (9.9%). See Table 1 for racial makeup. For counseling experience, 131 participants reported yes (65%), whereas, 71 (35%) reported not having experience receiving counseling services. Of these who reported yes, 37.6% reported current use ($n = 50$) and 62.4% reported prior use ($n = 83$),

Regarding sexual identity, 71.1% (n = 144) identified as heterosexual, 22.8% (n = 46) identified ass bisexual, 1.5 % (n = 3) identified as queer, 2 % (n = 1%) identified as lesbian, and 1.5% (n = 3) reported as other. Regarding geographic region, the participate pool represented almost every region evenly. Forty-four (21.8%) participants reported that they reside in the Northeast, 44 (21.8%) reported they resided in the Southeast, 35 (17.3%) stated they lived in the Midwest, 6 (3%) stated they lived in the Rocky Mountains, 41 (20.3%), indicated they resided in

the West Coast, 2 (1%) indicated they were from Alaska/Hawaii, and 30 (14.9%) were from the Southwest.

When inquiring about formal education and the highest degree obtained, 44 (21.8%) participants reported high school, 33 (16.3%) participants reported associates, 86 (42.6%) participants obtained a bachelors, 28 (13.9%) reported obtaining masters, 2 (1%) obtained a specialist degree, and 4 (2%) participants indicated achieving a doctorate. View Table 1 for additional demographic information.

Table 1

Demographic Data for Participants

Variable	*n*	%
Age (years)		
Range: 18– 60		
M = 29.85, *SD* = 7.92		
Gender Identity		
Cis-Female	119	58.9%
Cis-Male	71	35.15%
Trans Female	5	2.48%
Trans Male	7	3.47%
Race/Ethnicity		
Black and Asian	4	2%
Black and Hispanic	25	12.4%
Black and Native	2	1%
Black and White	36	17.8%
Hispanic and Asian	12	5.9%

Hispanic and Native	20	9.9%
White and Asian	22	10.9%
White and Hispanic	67	33.2%
White and Native	14	6.9%
Sexual Identity		
Heterosexual	144	71.3%
Bisexual	46	22.8%
Queer	3	1.5%
Lesbian	4	2%
Gay	2	1%
Other	3	1.5%
Religion/Spirituality		
Agnostic	45	22.3%
Atheist	18	8.9%
Buddhist	5	2.5%
Christian	105	52%
Hindu	3	1.5%
Muslim	2	1.0%
Other	24	11.9%

Procedures

Approval from the institutional review board (IRB) at the researcher's institution was secured before the start of the study. Before beginning the study, participants were required to review the electronic informed consent form, which informed participants that their involvement in the study was voluntary and they could discontinue their participation in the study at any time.

Once participants agreed to continue with the investigation, they completed the online surveys. The researcher recruited Biracial individuals via the M*Turks. M*Turks is a public online "crowdsourcing internet marketplace," which allows individuals and business to solicit individuals to perform "human intelligence" task that cannot be completed by a computer. Participants who met the criteria for this study and completed all five surveys, demographic survey, Multiracial Identity Integrations, Brief Perceived Ethnic Discrimination Questionnaire – Community Version, Self-Stigma of Seeking Help Scale, and Intentions to Seek Counseling Scale, were given .50 cents. The inclusion criteria for this study was that participants must self-identify as Biracial and be at least 18 years of age.

Measures

Demographic survey. The demographic questionnaire included participants' age, gender, and sexual identity, racial identity, their prior or current counseling experience (duration), religion, ability status, relationship status, education level, as well as, geographic location (see Appendix B). Respondents were given drop-down menus, sliding scales, and open entry text boxes to respond to the demographic questionnaire.

Multiracial Identity Integration. Multiracial (Biracial) Identity Integration (MII, see Appendix C). The MII is an eight-item scale used to measure two sub-scales that describe Biracial identity integration: racial conflict and racial distance. Each item consists of a 5-point Likert scale where one indicates completely disagree, two indicates somewhat differ, three indicates not sure, four indicates somewhat agree, and five indicates completely agree. Sample question includes "I feel like someone moving between the different racial identities." Higher scores on the scales indicate higher racial distance and racial conflict and indicate lower levels of MII. Cheng and Lee (2009) reported that in a pre and post-test data analysis procedure, "The

reliabilities of the sub-scales were high in both the pre (Cronbach's alphas for racial distance and racial conflict were .80 and .74, respectively) and posted administrations of the scale (Cronbach's alphas for racial distance and racial conflict were .77 and .70, respectively)" (pg. 58). Within Jackson et al. (2012) study, the MII scale's two sub-scales internal reliability was reported at .65 for Distance and .81 for Conflict. The Cronbach Alpha for the distance and conflict sub-scales within this study was .58 and.72, respectively. The full-scale yielded an alpha score of .72.

Brief Perceived Ethnic Discrimination Questionnaire – Community Version. The Brief Perceived Ethnic Discrimination Questionnaire-Community Version (BPEDQ-CV) is a 17-item scale that assesses the occurrence to which participants report experiencing discrimination from others based on ethnicity (see Appendix D). Each item consists of a 5-point Likert scale where 1 indicates never, 3 indicates sometimes, and 5 indicates very often. The Likert-scale number options 2, and 4 do not include specific meanings. The author revised the question probe before each question, "How often [in the last year]", which was future study suggestion in Cheng and colleagues (2013) to capture most recent discriminatory experiences. Sample questions include: Have others hinted that you are dishonest or can't be trusted? and (How often…) Have others ignored you or not paid attention to you? The four sub-scales including in this scale: Exclusion, Workplace discrimination, Stigmatization, and Threat and Harassment. Despite significant differences among sub-scale scores, F (3, 1002) = 153.76, $p < .01$ between the full version and brief version, Brondolo et al. (2005) report strong psychometric properties related to the Brief PEDQ-CV scale. The authors reported that though the scale has fewer items, the sub-scales of the Brief PEDQ-CV scale "had only slightly lower internal consistency than did the full sub-scales formed from the Lifetime Exposure scale of the PEDQ-CV" and "the pattern of scores

for the Brief PEDQ-CV was identical to that for the full PEDQ-CV" (p. 354, Brondolo et al., 2005). In McDonald, et al. (2019) study, the internal consistency of .94 was found with the BPEDQ-CV. Additionally, the BPEDQ-CV has a medium significant correlation with the Multiracial Identity Integration Scale ($r = .37$, $p < .01$). The Cronbach Alpha for the full scale was with this sample was .92. All sub-scales retained an alpha score of between .80 to .86 (Exclusion .80, Threat .86, Stigmatization .70, and Workplace .85).

Self-Stigma of Seeking Help Scale. The Self-Stigma of Seeking Help Scale (SSOSH, see Appendix E) is a 10-item instrument with statements rated on a 5-point scale ranging from (1) strongly disagree to (5) strongly agree (Vogel, Wade, & Hackler, 2007). Items include statements such as: "I would feel inadequate if I went to a therapist for psychological help" and "I would feel worse about myself if I could not solve my problems." Low stigma is associated with scores ranging from 10-22. Medium stigma is assigned for scores in the 23-32 range. Scores in the 33-50 range are regarded as having high stigmatizing beliefs. Validity was demonstrated moderately with intentions to seek counseling and attitudes toward seeking professional treatment. Internal consistency reliabilities ranged from .86-.90, test re-test reliability was .72 with college students (Vogel et al., 2006). A Cronbach alpha .86 with Black, Asian, and Latino individuals (Cheng et al., 2013). The Cronbach alpha for this scale was .81.

Intentions to Seek Counseling Inventory. The Intentions to Seek Counseling Inventory (ISCI, see Appendix F) is a 17-item instrument with questions rated on a 4-point scale ranging from (1) very unlikely to (4) very likely (Cash, Begley, McCown, & Weise ., 1975). Participants using the instrument are asked to respond to questions asking how likely they would be to seek counseling for various concerns (depression). The instrument assesses their willingness to seek counseling and psychological treatment based on different problems listed, ranging from

depression and relationship difficulties to academic concerns and substance abuse (Cash et al., 1975). Low scores are in the 17-34 range, moderate scores are in the 35-67 range, and scores from 51-68 are considered high. The Intentions to Seek Counseling Inventory contains three sub-scales: Psychological and Interpersonal Concerns (10 items; $\alpha = .90$), Academic Concerns (4 items; $\alpha = .71$), and Drug Use Concerns (2 items; $\alpha = .86$). This study replicated the strategy of Vogel et al. (2007), only the Psychological and Interpersonal Concerns sub-scale was used, which was found to support criterion validity for the SSOSH measure. Internal consistency of the Psychological and Interpersonal Concerns sub-scale was .87 in a college student population (Cash et al., 1975). For this study, the Cronbach Alpha for this scale was .90.

Results

Preliminary Analysis

Data was downloaded from www. qualtrics.com onto an SPSS file. The data was cleaned and screened for violation of assumptions for multiple regression, linearity, homoscedasticity, multicollinearity using correlation matrix and normality (i.e., skewness and kurtosis). In total, 469 participants began the survey of which 267 were deleted for the study's main analysis. More specifically, 177 were removed because they did not complete the survey. Fourteen participants were deleted from the study because they reported they identified as Hispanic, but they did not meet criteria (i.e., selected "Other" for ethnic identity but filled in text "White"). Forty-four participants selected Biracial identity but only selected one racial group or selected other and included the same racial group (i.e., selected White European / Caucasian, Other, and in text wrote White). Also, 19 participants were deleted because they were Multiracial (e.g., identifying with more than two racial make-ups). Lastly, 13 participants were removed for missing three validity checks. Ten outliers were identified when reviewing the boxplots. However, the outliers

did not impact the overall mean scores with the 5% trimmed mean differences being less than .2. As a result, of the 469 sample pool, a total of 202 (43.07%) participants were used in the final analysis. The result of Little's MCAR test (Fichman & Cummings, 2003; Little, 1988) demonstrated a nonsignificant result, ($x^2 = 52.424$, $df = 56$, $p = .611$), thus reporting that the data was missing completely at random. The most common pattern for missing data was for age, missing data for 13.4% of the sample. As a result of the low percentage of missing data analysis, multiple imputations were not desirable. The variables of interest were in the acceptable range of skewness. Also, parametric and nonparametric tests revealed no differences were statistically significant on the SSOSH, ISCI, and the MII and BPEDQ-CV and its sub-scales.

T-test and ANOVA. There was a significant group difference for gender and counseling attendance in mean scores on the BPEDQ-CV full-scale and sub-scales (stigmatization and threat), and SSOSH full-scale. The sub-scale scores for the BPEDQ-CV stigmatization were significantly higher for men ($M = 9.60$, $SD = 3.41$), than women ($M = 8.40$, $SD = 3.21$, $t(200) = -.82$, $p = .01$). Similarly, the sub-scale scores for the BPEDQ-CV threat men scored higher ($M = 8.05$, $SD = 4.39$) than women ($M = 6.46$, $SD = 3.47$), $t(200) = -.82$, $p < .01$, suggesting that men for this sample had higher perceived discrimination threat and stigmatization as compared to women. Additionally, there was a difference in mean scores for gender, men scored higher ($M = 29.03$, $SD = 7.63$) than women ($M = 26.2339$, $SD = 7.76$) on the SSOSH full-scale $t(200) = -2.51$, ($p = .01$). A t-test found the effect on attending counseling significant on the ISCI full-scale, those who self-reported "Yes" scored significantly higher ($M = 38.07$, $SD = 10.62$) than those who reported "No" ($M = 33.10$, $SD = 11.96$), $t(200) = 3.04$, $p < .01$. In addition, on the SSOSH full-scale those who selected "No" had a higher score ($M = 30.35$, $SD = 7.24$) than those who self-reported "Yes" having counseling experience ($M = 25.66$, $SD = 7.64$), $t(200) = -4.24$, p

< .01. A *Bonferroni Correction* test was conducted for each t-test that revealed a significant group differences to ensure that a type 1 error did not occur. Significant differences were observed for all t-test analysis addressed above with an alpha corrected score of .01.

With the one-way ANOVA analysis, group differences were observed between racial make-up. The racial group Black and Asian (n = 4) and Black and Native (n = 2) were combined to make Black and Asian or Native racial category (n = 6). This was created because ANOVA analysis in SPSS was unable to run because of small group sizes for both groups. When assessing the multiple racial identity make up there appeared to be a consistent difference on the full-scale MII scores F (7, 194) = 2.91, p < .01. A post hoc *Bonferroni Correction* test was conducted which resulted in no significant group differences for Biracial make-up. Group differences were identified when assessing the MII distance scale scores F (7, 194) = 2.82, p < . 01 where the Hispanic and Native (M = 11.40; SD = 2.91) group scored significantly higher than Black and White (M = 8.39; SD = 3.20) a post hoc *Bonferroni Correction* test. A small effect (.10) was identified for this group mean differences (Cohen, 1988).

Group differences were observed for group means for Biracial identity make-up F(7, 194) = 4.40, p < .001 and U.S. geographic region F(6, 195) = 2.45, p < .01 on the BPEDQ-CV full-scale. For Biracial identity make-up, the assumption of homogeneity of variances was significant (p = .03), presumably because the categories were unequal. For this reason, the *Games-Howell* post hoc test was administered to determine which groups differed significantly (Fields, 2013; Leech, Barrett, & Morgan, 2015). The *Games-Howell* test revealed that full-scale BPEDQ-CV scores were significantly higher for the Black and Hispanic (M = 36.80; SD = 13.60), White and Hispanic (M = 34.15; SD = 12.64), Hispanic and Asian (M = 41.25; SD = 13.25), Hispanic and Native (M = 41.80; SD = 13.34) groups than for the White and Native

group (M = 23.93; SD = 9.34). Also, BPEDQ-CV full-scale scores were significantly lower for the Black and White (M = 30.22; SD = 10.35), White and Asian (M = 28.64; SD = 10.53) groups than Hispanic and Native (M = 41.80; SD = 13.34). For geographic region, the assumption of homogeneity of variances was significant ($p < .01$), one reason is because the categories were unequal. For this reason, the *Games-Howell* post hoc test was administered to determine which groups differed significantly (Fields, 2013; Leech, Barrett, & Morgan, 2015). The *Games-Howell* test revealed that those residing in the Southwest (M = 37.26; SD = 13.34) scored significantly higher than those residing in the Southeast (M = 27.61; SD = 13.34). Also, those residing in Alaska/Hawaii (M = 47; SD = 1.41) scored significantly higher than every other region (Midwest, Northeast, Rocky Mountain, Southeast, Southwest, and West Coast), mean scores ranging 27.61 (Southeast) to 37.26 (Southeast).

As for the sub-scales of the discrimination measure, the BPEDQ-CV threat significant groups differences were revealed for religious affiliation F (6, 195) = 4.18, $p < .01$. There was a significant group differences observed for the Agonistic group (M = 5.71; SD = 2.99) which scored significantly lower on the sub-scale than the Buddhist (M = 11.40; SD = 4.16) when conducting a post hoc *Bonferroni Correction* test..

Other group differences were found for religious afflation for the sub-scale MII distance F (6, 195) = 2.45, p = .03. However, when assessing the post hoc *Bonferroni Correction* test, no specific significance amongst groups were revealed. Group difference on the sub-scale MII conflict for U.S. regions F (6, 195) = 2.45, p = .03 were revealed but the post hoc *Bonferroni Correction* comparison amongst groups was not significant. Group difference were observed for religious affiliation on the full-scale ISCI F (6, 195) = 2.62, p = .02. When reviewing the post hoc comparison *Bonferroni Correction* test no significant group differences were identified.

Main Analysis

Multiple analyses were conducted including correlation, hierarchical multiple regression analysis, and moderation analysis. The MII and BPEDQ-CV measures have full-scale and sub-scale scores. The SSOSH and ISCI solely produced full-scale scores. Full-scale scores were analyzed first. Descriptive statistics (i.e., means and standard deviations) and Cronbach's alpha coefficient for reliability were calculated for the study measurements and sub-scales. A summary of descriptive statistics for the measurements is included in Table 2. According to DeVellis (2012), the Cronbach alpha coefficient of a scale should be above .70. The reliability for all but one of the subscale (MII Distance) was above .70.

Table 2
Descriptive Statistics and Reliability of Study Instruments

Study Instruments	Cronbach α	No. of Items	M (SD)
MII	.72	8	20.04 (6.22)
Distance	.58	4	9.30 (3.37)
Conflict	.72	4	10.74 (4.13)
BPEDQ-CV	.92	17	33.61 (12.91)
Workplace	.85	4	7.91 (3.79)
Threat	.86	4	7.07 (3.92)
Stigmatization	.70	5	8.87 (3.33)
Exclusion	.80	4	9.76 (4.08)
SSOSH	.81	10	27.31 (7.81)
ISCI	.90	17.	36.32 (11.34)

Note. Abbreviations: MII = Multiracial Identity Integration Scale; BPEDQ-CV = Brief Perceived Ethnic Discrimination Questionnaire - Community Version; SSOSH = Self-Stigma of Seeking Help Scale; ISCI = Intentions to Seek Counseling Inventory.

Correlation analysis. To understand the relationship between the scales (MII, BPEDQ-CV, SSOSH, and ISCI) and sub-scales, a bivariate correlation was conducted (Research question 1). The correlation demonstrated significant relationships among the study's variables (see Table 3). The MII full-scale had a significant medium correlation with BPEDQ-CV full-scale scores (r = .426, p < .01) with n = 202. This relationship indicated that the more Biracial individuals are exposed to experiencing discrimination, the more likely they will experience distance or conflict with their racial identity. MII full-scale also had a significant medium positive correlation with SSOSH (r = .373, p < .01) with n = 202 and a small positive correlation with ISCI (r = .268, p < .01) with n = 202. The results suggest that the more integrated a Biracial individuals' racial identity is they will be less likely to experience self-stigma of seeking help. BPEDQ-CV was positively correlated with MII (r = .260 p < .01) with n = 202 and a medium positive correlation with SSOSH (r = .373, p < .01) with n = 202. No significant relationship was found between SSOSH and ISCI.

Table 3
Correlations Between Study Variables

Variables	1	2	3	4
1. MII	__			
2. BPEDQ-CV	.426**	__		
3. SSOSH	-.373**	.260**	__	
4. ISCI	.268**	.429**	-1.00	__

Note. *$p < .05$. **$p < .01$. Abbreviations: MII= Multiracial Identity Integration; BPEDQ-CV = Brief Perceived Experience Discrimination Questionnaire – community version; SSOSH = Self-Stigma of Seeking Help; and ISCI = Intentions to Seek Counseling

Hierarchical multiple regression. To examine the second research question which sought to understand what variables predicted intentions to seek counseling. As a result of the multiple group differences observed in the t-test and ANOVA analysis a hierarchal multiple linear regression was conducted to assess the ability of MII, BPEDQ-CV, and SSOSH measures to predict ISCI after controlling for gender, Biracial make-up, U.S. geographic region, religion, and counseling experience. When assessing the coefficients table for normality, multicollinearity violations, the tolerance for all three variables was higher than .10, and their VIF is not above 10 which states each variable does not violate the multicollinearity assumption. Also, preliminary analysis conducted that revealed no violation of the assumptions for linearity and homoscedasticity. All demographic variables (i.e., gender, Biracial make-up, U.S. geographic region, religion, and counseling experience) that were found to have significantly different group means were included in step 1, explaining 6.7% of the variance in ISCI $F(5, 196) = 2.81$, $p = .02$, $R^2 = .067$, Adjusted $R^2 = .043$. For step 2, MII, BPEDQ-CV, and SSOSH was included and explained 32.1%, $F(8, 193) = 11.40$, $p < .001$, $R^2 = .321$, Adjusted $R^2 = .293$, of the variance for the whole model. After controlling for gender, Biracial make-up, U.S. Region, Religion, and counseling experience, the measures MII, BPEDQ-CV, and SSOSH accounted for an additional 25.4% of the variance on ISCI, *R* squared change = .25, $F(3, 193) = 24.07$, $p < .001$, $R^2 = .321$, Adjusted $R^2 = .293$. In the final model, all three measures and three of the five demographic variables were significant (gender and Biracial make-up was not), with BPEDQ-CV scoring the highest beta value (beta = .44, p < .001) and religious affiliation with the lowest beta value (beta = -.4, p = 03), see Table 4 below for regression analysis.

Table 4
Summary of Hierarchical Regression Analysis for Variables Predicting Intentions to Seek Counseling

	Step 1			Step 2		
Variable	*B*	*SE B*	*β*	*B*	*SE B*	*β*
Demographic						
Gender	.62	1.65	.03	-.90	.1.45	-.04
Biracial Make-up	.13	.43	.02	.06	.38	.01
Counseling. Exp.	-4.96	1.68	-.21**	-3.74	1.51	-.16*
U.S. Geo Region	-.43	.34	-.09	-.69	.29	-.14*
Religious Aff.	-.64	.38	-.12	-.75	.34	-.14*
Measures						
MII				.35	.13	.19**
BPEDQ-CV				.39	.06	.44**
ISCI				-.29	.10	-.20**
R^2		.067			.321	
F for change in R^2		2.806*			24.067**	

Note: Counseling. Exp. = Counseling Experience; U.S. Geo Region = U.S. Geographic Region; Religious Aff. = Religious Affiliation; *$p < .05$. **$p < .01$.

Moderation. For question three and four, moderation was used to assess if SSOSH would moderate the relationship between MII and ISCI (question 3) and BPEDQ-CV and ISCI (question 4). To assess the moderating relationships, the researcher used Hayes' PROCESS Macro model one on SPSS (Hayes, 2013). Overall, the model summary revealed that the interaction between MII and SSOSH significantly predicted ISCI F (3,198) = 10.60, $p < .01$, R^2 = .14. Moreover, MII positively predicted ISCI, b = .64, t(198) = 4.96, $p < .01$. For every 1 unit

increase in MII score (self-report rating on MII assessment), we get a .643 unit increase in ISCI score. SSOSH negatively predicted ISCI, $b = .30$, $t(198) = -2.81$, $p < .01$. For every 1 unit increase in SSOSH (self-report rating on SSOSH assessment), we get a -.295 unit decrease in ISCI score. Interaction of MII and SSOSH predicted ISCI, $b = .03$, $t(198) = 2.16$, $p = .03$. See Figure 1 for a graph of analysis.

For a low score on the SSOSH scale, MII $b = .397$ $t(198) = 2.29$, $p = .02$, every increase in MII score it increases the ISCI score by .397 points. For moderate scores on the SSOSH scale, MII $b = .643$ $t(198) = 4.96$, $p < .01$, every increase in MII score increases the ISCI score by .643 points. For a high score on the SSOSH scale, MII $b = .889$ $t(198) = 5.18$, $p < .01$, an increase in MII score increases the ISCI score by .889 points. The results suggest that SSOSH impacted the relationship between MII and ISCI, regardless of score on the MII (e.g., low, moderate or high) or the ISCI (low, moderate, or high). In other words, as SSOSH increased for those with either a fully integrated identity (low on MII scale) and conflicted or distance racial identity (high on racial identity scale) their intentions for seeking counseling decreased significantly. Also, those who had a fully integrated racial identity were more likely to not seek counseling than their counterparts who scored high on the MII. Moreover, when participants received a score of 18 or higher on the SSOSH measure, MII and ISCI was significantly related $t(36) = 1.97$, $p = .05$, $b = .36$. As scores on the SSOSH increases, the relationship between MII and ISCI becomes more positive with the highest SSOSH scores (50), $b = 1.36$, $t(36) = 3.84$, $p < .01$.

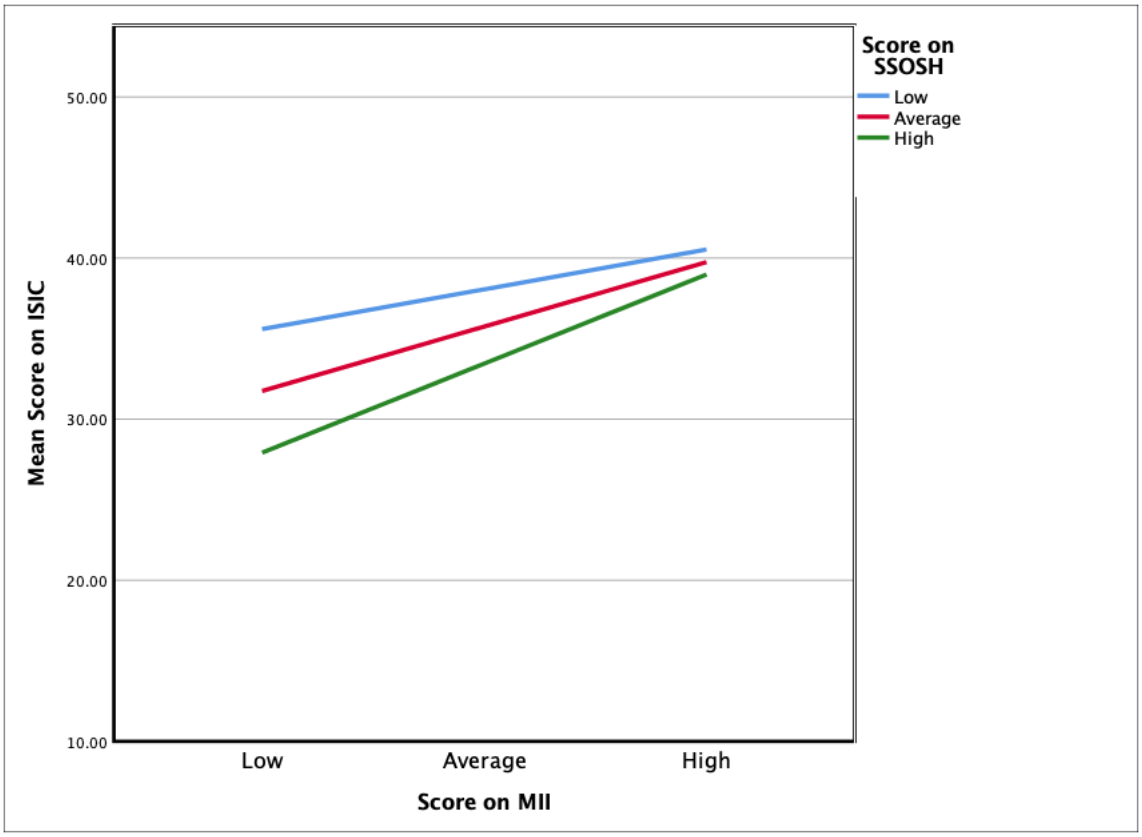

Figure 1. Hayes Process Macro Moderation Analysis for Intentions to Seek Counseling

For question four, two independent variables included in the analysis: BPEDQ-CV and SSOSH. The Hayes Process analysis revealed that the overall interaction was significant $F(3,198) = 19.94$, $p < .01$, $R^2 = .23$. BPEDQ-CV positively predicted ISCI, $b = .42$, $t(198) = 6.99$, $p < .01$. SSOSH negatively predicted ISCI, $b = -.33$, $t(198) = -3.0552$, $p < .01$. Interaction of BPEDQ-CV and SSOSH did not predicted ISCI, $b = .002$, $t(198) = .2396$, $p = .81$. SSOSH did not moderate the relation between discrimination and intentions to seek counseling.

Discussion

Research investigating the lived experience of the Biracial population is limited within the field of counseling. Researchers are beginning to unpack the experiences of Biracial individuals by assessing their identity development (Henriksen & Paladino, 2009; Root, 2003)

and exposure to monoracism (Franco & O'Brien, 2018; McDonald et al. 2019). There is limited information on Biracial individuals' use of counseling and factors that contribute to how or when they might be more susceptible to seeking counseling services. Bearing in the mind that two or more races category change in the 2000 US Census, this study strives to uncover the wholeness of the Biracial population's exposures within our current sociocultural environment and their self-help behaviors. Within the counseling profession, we have an opportunity to strengthen best practices and competencies (Kenney et al., 2015) when working with this population.

In this study, MII was significantly related to BPEDQ-CV, SSOSH, and ISCI. BPEDQ-CV was significantly related to SSOSH and ISCI. Despite previous literature suggesting that discrimination is a deterrent to seeking psychological help (Lamkaddem, Essink-Bot, Deville, Foets, & Stronks, 2011; Yasui et al., 2015), this study's findings support that as Biracial individuals are exposed to increased discrimination through threat and stigmatization about their racial identity, their intentions to seek counseling increases. Similarly, as Biracial participants identity became more conflictual or they experienced more distance amongst their mixed racial identity their intentions to seek counseling increased. Although the findings are contradictory to some literature on POC that reported higher distress or exposure to discrimination would make POCs less likely to seek counseling (Carter & Forsyth, 2010, Kim & Zane, 2016) the findings provides an alternative narrative for other POC that counseling is seen as a resources rather than a barrier when experiencing societal stressors. Furthermore, the findings from this study further support the counter idea in other literature that other POC (Biracial individuals) seek psychological help in response to experiences of discrimination (Richman et al. 2007).

Similarly, to previous literature (Richman et al., 2007; Yasui et al., 2015), the findings imply a relationship between Biracial individuals with lower scores on the MII were perceived as

having an integrated racial identity and were less likely to seek counseling. Of all three variables, self-stigma was the only variable that was not correlated with intentions to seek counseling.

For this sample, MII and BPEDQ-CV significantly predicted ISCI. The findings counter previous literature that states POC who experience discrimination were less likely to use counseling. It also adds to the gap in the literature that experiences of discrimination will increase the likelihood that Biracial individuals will attend mental health services. Knowing that Biracial individuals are willing to seek mental health services is encouraging and is a reminder that POC are not monolithic in their experiences. Self-stigma was found to predict intentions to seeking counseling. SSOSH has been a long predictor of intentions to seeking (Vogel et al. 2006) with POC (Loya et al., 2010) and adds that Biracial individuals, too, are influenced by stigmatizing beliefs about mental health which hinders their health seeking behaviors. It is also important to note that SSOSH, MII, and BPEDQ-CV predicted ISCI even when controlling for age, Biracial make-up, U.S. geographic region, religious affiliation, and counseling experience, suggesting that SSOSH, MII, and BPEDQ-CV have a unique and separate relationship with ISCI. This provides an explanation that Biracial individuals have intentions to seek help regardless of certain demographic identities that could pose as barriers to their mental health use, such as, gender or counseling experience.

Although self-stigma of seeking help did not correlate with intentions to seek counseling it was found to moderate the relationship between Biracial identity and intentions to seek counseling. Self-stigma had a moderating relationship between Biracial identity and intentions to seek counseling, surprisingly, for those participants with an integrated racial identity and participants with a conflicted racial identity. The minority stress theory explains some of the findings from this study, for instance, when people from marginalized backgrounds experience

external stressors (awareness of racial stereotypes or prejudicial beliefs about one's identity), such as experiencing conflict within their racial identity, coupled with the fear of being stigmatized as being someone "mental unhealthy", they are more likely to underuse health services (Pieterse, Todd, Neville, & Carter, 2012; Pittman, Cho Kim, Hunter, & Obasi, 2017). Even though it was surprising that SSOSH was not correlated with ISCI, it was noteworthy to see that when SSOSH was included in the relationship between MII and ISCI, it changed the relationship from positive to negative. For instance, for Biracial individuals in the study with a conflictual racial identity and who held self-stigmatizing beliefs toward counseling, they were more likely to underutilize counseling. Since SSOSH moderated the relationship between MII and ISCI but did not correlate with ISCI, a possible explanation is when SSOSH is the moderator, it might be capturing other confounding variables, such as social, economic status and lack of health insurance. Although these variables were not assessed in this study, other reports have identified them as additional factors that impact counseling utilization (Office of Minority, 2004; SAMSHA, 2017).

Biracial individuals who perceived discrimination at a higher rate were more likely to seek counseling and were not affected by stigmatizing beliefs about mental health. The results further showcase the resiliency and self-efficacy of Biracial individuals to seeking help despite potential lingering negative beliefs about mental health. One explanation could be that the current sociopolitical environment for Biracial individuals, and their exposure to discrimination is higher than in years past. As a result, there is more of a focus on seeking help for the distress that discrimination causes rather than the possible fear of being perceived as someone who has a mental health issue.

When assessing group differences, gender, Biracial make-up, and those with or without counseling experiences responded differently on certain scales. Moreover, group mean differences were discovered between men and women for the BPEDQ-CV full-scale and on two sub-scales (threat and stigmatization) and the SSOSH. Consistent with the literature, men of color are reported as experiencing more physical threat than women (Rich, 2018). As expected, there was a difference in mean scores between those with counseling experience and those with no counseling experience on the SSOSH and ISCI full-scales. Additionally, what was surprising, mean scores differences were observed on the BPEDQ-CV threat sub-scale, as well, for this group. Group differences were also observed between Biracial make-up groups on the BPEDQ-CV full-scale, BPEDQ-CV sub-scale (threat), MII full-scale, and sub-scale (conflict). More specifically, Biracial individuals with a racial make-up of Hispanic and Native American reported significant more perceived discrimination (threat), and multiracial identity distance compared to other biracial make-up groups. This finding is not surprising being that currently sociopolitical prejudicial thinking and discriminatory acts have increased from 9.4 percent to 10.9 percent from 2015 to 2017 for Hispanic/Latinx individuals in America over the past several years (Federal Bureau Investigation [FBI], 2016; 2017).

Counseling Implications

The finding that POCs underutilize counseling in previous literature (Abe-Kim, et al., 2007; Carter & Forsyth, 2010; Cook, et al. 2012; Office of Minority Health, 2004; SAMSHA, 2017) was countered by the current study's findings as a result that 65.5 percent (131 out of 202) of this study's sample reported previous or current counseling use. Moreover, this study uncovered that Biracial individuals reported utilizing counseling at a higher rate when they perceived discrimination and when they experienced challenges with their racial identity

(Biracial conflict or distance). This is a good place to target interventions for counselor educators who are working with counselors in training to inform best practice techniques with Biracial individuals further. As revealed with the findings from this study and reported in other studies that Biracial individuals are, too, at risk to experience discrimination that makes them more susceptible to psychological distress (Franco & O'Brien, 2018; Jackson, 2009) and is imperative for professional counselors to recognize and reduce prejudices, stereotypes, and monoracism. As shown in this study, experiences of discrimination was a stronger reason to seek counseling for this group than was the impact of mental health stigma decreasing potential use of counseling. Additionally, no difference in counseling use was observed in this study for those with an integrated Biracial identity or challenged Biracial identity. Professional counselors working with this population should be aware of the influence of these psychocultural factors, such as, racial identity, discrimination, and self-stigma of mental health. Counselor educators can begin this work by offering the opportunity for Biracial individuals to come to their classes to speak with students so that students can connect with Biracial individuals and share narratives and deconstruct misperceptions about this group and Biracial individuals can discuss the nuances of discrimination that is particular to Biracial individuals. By giving students the opportunity to meet and learn from Biracial individuals, it will provide a context to the information they are learning about marginalized individuals and will assist in identifying the specific needs of this group. In response, counselors-in-training will be able to better support and advocate for this group in their professional work.

Along with training students on how to work with this population, Counselor Educators should be sure to not only incorporate the Multicultural and Social Justice Counseling Competencies (Ratts, et al., 2016) to address the impact privileged and oppressed intersecting

racial identities for Biracial individuals but also introduce students to the Competencies for Working with the Multiracial Population (Kenney, et al., 2015). Being aware of how social political identities impact individuals' lived experience is foundational for Biracial individuals whose racial identity is often challenged and discredited. Another suggestion would be to discuss the impact of monoracism in addition to racism Biracial individuals experience. By being aware of the covert and overt experiences of monoracism professional counselors can better advocate on behalf of this population. The initial dialogue could be done by discussing racial identity formation and adding Biracial identity to the discussion.

Self-stigma of mental health has been a known contributor to the decrease use of counseling services (Vogel et al., 2006). The same effect has been discovered in this study for Biracial individuals. Biracial individuals, too, are at risk for indoctrinating beliefs and attitudes of "rightness" despite their existence of being mixed race is perceived as a social deviation (i.e., holding two racial group make-up status regardless of what [Bi]racial identity they identify with). Another suggestion would be to advocate on behalf of the field of counseling and focus on dispelling the myths or misperceptions about mental health and counseling. One suggestion to effectively do this would be to train counseling students about the impact of mental health stigma for this group. Additionally, community outreach is an effective technique to reach those who are less likely to seek counseling and might be deterred to attend due to stigmatizing beliefs they have about counseling. Community outreach can be done through social media campaigns, attending community clubs (virtually and in-person), and through one on one interactions with Biracial clients by broaching the conversation.

Limitations and Future Research

The primary limitation of this study is that we used measurements that were normed on monoracial samples for Biracial participants, except for the MII. The MII scales Cronbach's alpha level, although lower than expected, are not surprising. The researcher has suggested as a result of the complexity of ethnicity and race research, that relying on traditional psychometrics approaches for establishing reliability is unwise (Trimble, 2007). Furthermore, acceptable alpha values in the early stages of research within psychological constructs range between .50-.70. (Field, 2013) so the measure was found best suited for the study. Another limitation is that the sample represents Biracial individuals from nine different Biracial makeup (i.e., Black and Hispanic, White and Asian, and, Hispanic and Native, etc.). The participant sample would have benefited from coming from a more homogenous group. Another limitation was a high participant dropout rate from the M*Turks crowdsourcing website. A total of 177 did not complete the study and another 99 were removed for either not meeting research criteria or missing attention check questions. Despite participants being paid 50 cents this number is larger than expected.

The findings of this study benefited the field of counseling considering that within the U.S., the Biracial population is steadily growing which increases the likelihood of providing counseling to those within this population and more research is needed. The higher the demand for professional counselors to increase competence and learn how to work with people from diverse background adequately justifies the need for more effective, multicultural competent training, and clinical practice. Future studies would be beneficial to identify measurements that are normed for Biracial and Multiracial individuals (Franco & O'Brien, 2018). Researchers investigating similar constructs on this particular population should focus on one Biracial

makeup group rather than multiple. Those within the Biracial population lived experience is not monolithic; their racial identity is fluid and can be impacted by social constructs of race and how race is categorized. For example, colorism and phenotypic features that may suggest a particular racial background (e.g., darker skin complexion could be assumed to have minority racial background, for example, Black/African American heritage) which makes that person more susceptible to racism and discrimination. Future studies could benefit from being intentional in their participant sampling of Biracial make-up and assessing their perceived racial make-up by others. Lastly, research could focus on other factors that could hinder counseling use for this group, such as, social economic status or access to health insurance.

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APPENDIX A

Georgia State University
Department of Counseling and Psychological Services
Informed Consent

Title: Influences of Psychocultural Factors and Self-Stigma of Seeking Psychological Help on Multiracial Individuals' Counseling Utilization

Principal Investigator: Catharine Chang, Ph.D., LPC, NCC, CPCS

Student Principal Investigator: Mary Huffstead, M.Ed., LPC, NCC

Purpose

You are invited to participate in a research study. The goal of this study is to investigate the relationships between racial identity, self-stigma of seeking psychological help and counseling utilization of Biracial Individuals. You are invited to participate because you identify as Biracial of Black and White racial background. A total of 200 volunteers will be recruited for this study. Participation will require approximately 20-40 minutes of your time over one participation sitting. Your participation is completely voluntary, and you can withdraw from participating at any time.

Procedures

You are being asked to take part in a research study. If you decide to participate, you will be asked to fill out a series of online questionnaires, including a brief demographic questionnaire. Participation includes a one-time, approximately 20-40-minute time commitment, to take place at the time and location of the participants' choosing. This study is confidential and will not ask for your name at any time.

Compensation

Volunteers recruited through the Counseling and Psychological Services department SONA system, will be eligible for .5 credits for their involvement in this study. Volunteers through the M*Turks Amazon software will be compensated 50 cents for their involvement in this study.

Voluntary Participation and Withdrawal

You do not have to be in this study. You may skip questions or stop participating at any time. If you decide to be in the study and change your mind, you have the right to drop out at any time. You may skip questions or stop your involvement at any time. Whatever you decide, you will not lose any benefits to which you are otherwise owed to you.

Copy of Consent Form to Participant

If you agree to participate in this survey, please continue with the survey. You may print a copy of this form for your records.

Appendix B

Demographic Questionnaire

1. Age: _____

2. Do you identify as Biracial or Multiracial?

3. Please select a racial, ethnic, and/or cultural groups you identify with:

- African American/Black
- Asian or Pacific Islander
- European American/White
- Latino/a or Hispanic
- Middle Eastern
- Native American
- Other? Please specify: _____

4. Please select the racial, ethnic, or cultural identity that you believe others assume you to be.

- African American/Black
- Asian or Pacific Islander
- Biracial (Please specify): _____
- European American/White American e. Latino/a or Hispanic
- Middle Eastern
- Multiracial (Please specify): _____
- Other? Please specify: _____

5. Please select your biological sex assigned at birth:

- Female
- Male

6. Do you identify as transgender?

- Yes
- No

7. Please select your sexual orientation / sexual identity:

- Bisexual
- Gay
- Heterosexual
- Lesbian
- Queer
- Other? Please specify: _____

8. Please select your relationship or marital status:

- Civil Union
- Divorced
- Domestic Partnership
- Married
- Single
- Unmarried and living in the same household
- Widowed

9. Please select your religious, spiritual, or other belief identification:

- Agnostic
- Atheist
- Buddhist
- Christian
- Hindu
- Jewish
- Muslim
- Other? Please specify: _____

10. Please select the kind of community where you live:

- Urban / Metropolitan / City location
- Suburban location outside of a Metropolitan location
- Town or village location
- Rural location

11. Please indicate in which area of the US you live:

- Northeast
- South
- Midwest
- Rocky Mountains
- West Coast
- Alaska / Hawaii
- Not applicable

12. Please indicate the highest degree, of any kind, that you have attained:

- High School
- Associates
- Bachelors
- Masters
- Specialist
- Doctorate

- Other? Please specify: _____

13. If you are a current student, please indicate your class standing:

- First Year/Freshman
- Second Year/Sophomore
- Third Year/Junior
- Fourth Year/Senior
- Fifth Year

14. Do you have a disability (e.g., hearing, seeing, moving, medical, psychological, learning)?

- Yes
- No

Appendix C

Multiracial Identity Integration Scale

Please read the statements below and rate the extent to which they describe your multi-racial experience. Please put the appropriate number in the box.

completely disagree	somewhat disagree	not sure	somewhat agree	completely agree

1----------2----------3----------4----------5

	Put Number Here ↓
1. My racial identity is best described by a blend of all the racial groups to which I belong.	D1 (r)
2. I keep everything about my different racial identities separate.	D2
3. I am a person with a multiracial identity.	D3 (r)
4. In any given context, I am best described by a single racial identity.	D4
5. I am conflicted between my different racial identities.	C1
6. I feel like someone moving between the different racial identities.	C2
7. I feel torn between my different racial identities.	C3
8. I do not feel any tension between my different racial identities.	C4 (r)

Note: D1-D4: Distance Scale, high score indicates perceptions of high distance (low MII)
C1-C4: Conflict Scale, high score indicates perceptions of high conflict (low MII)
(r) is reversed coded.

Appendix D

Brief PEDQ- Community Version

Think about your **ethnicity/race**. What **group** do you belong to? **Do you think of yourself as**: Asian? Black? Latino? White? Native American? American? Caribbean? Irish? Italian? Korean? Another group?

YOUR ETHNICITY/RACE: _____

How often have any of the things listed below happened to you **in the past year, because of your ethnicity/racial make-up**?

BECAUSE OF YOUR ETHNICITY/RACE …

A. **How often in the past year…**	**Never**		**Sometimes**	**Very Often**
1. Have you been treated unfairly by teachers, principals, or other staff at school?	1	2	3	4 5
2. Have others thought you couldn't do things or handle a job?	1	2	3	4 5
3. Have others **threatened** to hurt you (ex: said they would hit you)?	1	2	3	4 5
4. Have others **actually** hurt you or tried to hurt you (ex: kicked or hit you)?	1	2	3	4 5
5. Have policemen or security officers been unfair to you?	1	2	3	4 5

6. Have others **threatened** to damage your property?	1	2	3	4
	5]			
7. Have others **actually** damaged your property?	1	2	3	4
	5			
8. Have others made you feel like an outsider who doesn't fit in because of your dress, speech, or other characteristics related to your ethnicity?	1 5	2	3	4
9. Have you been treated unfairly by co-workers or classmates?	1 5	2	3	4

BECAUSE OF YOUR ETHNICITY/RACE …

How often in the past year…	**Never**		**Sometimes**	**Very Often**
10. Have others hinted that you are dishonest or can't be trusted?	1 5	2	3	4
11. Have people been nice to you to your face, but said bad things about you behind your back?	1 5	2	3	4
12. Have people who speak a different language made you feel like an outsider?	1 5	2	3	4
13. Have others ignored you or not paid attention to you?	1 5	2	3	4

Appendix E

Self-Stigma of Seeking Help

INSTRUCTIONS: People at times find that they face problems that they consider seeking help for. This can bring up reactions about what seeking help would mean. Please use the 5-point scale to rate the degree to which each item describes how you might react in this situation.

1 = Strongly Disagree
2 = Disagree
3 = Agree & Disagree Equally
4 = Agree
5 = Strongly Agree

1. I would feel inadequate if I went to a therapist for psychological help.
2. My self-confidence would NOT be threatened if I sought professional help.
3. Seeking psychological help would make me feel less intelligent.
4. My self-esteem would increase if I talked to a therapist.
5. My view of myself would not change just because I made the choice to see a therapist.
6. It would make me feel inferior to ask a therapist for help.
7. I would feel okay about myself if I made the choice to seek professional help.
8. If I went to a therapist, I would be less satisfied with myself.
9. My self-confidence would remain the same if I sought professional help for a problem I could not solve.
10. I would feel worse about myself if I could not solve my own problems.

Items 2, 4, 5, 7, and 9 are reverse scored.

Appendix F

Intentions to Seek Counseling Inventory

Using the scale below, please respond to each of the following statements

(1) Very Unlikely (2) Unlikely (3) Likely (4) Very Likely

1. How likely would you be to seek counseling for: Weight Control
2. How likely would you be to seek counseling for: Excessive Alcohol Use
3. How likely would you be to seek counseling for: Relationship Difficulties
4. How likely would you be to seek counseling for: Concerns about Sexuality
5. How likely would you be to seek counseling for: Depression
6. How likely would you be to seek counseling for: Conflicts with Parents
7. How likely would you be to seek counseling for: Speech Anxiety
8. How likely would you be to seek counseling for: Difficulty with Dating
9. How likely would you be to seek counseling for: Choosing a Major
10. How likely would you be to seek counseling for: Difficulty in Sleeping
11. How likely would you be to seek counseling for: Drug Problems
12. How likely would you be to seek counseling for: Inferiority Feelings
13. How likely would you be to seek counseling for: Test Anxiety
14. How likely would you be to seek counseling for: Difficulties with Friends
15. How likely would you be to seek counseling for: Academic work procrastination
16. How likely would you be to seek counseling for: Self-understanding
17. How likely would you be to seek counseling for: Loneliness